

S.J.P. INSURANCE SERVICES

Toll Free: (800) 479-5877
Fax: (805) 308-0764
sjpinsuranceservices.com

CERTIFICATE OF INSURANCE REQUEST

Fill out a form for each Certificate Holder.

Business Name: _____
Policy#: _____
Certificate Holder Name: _____
Address: _____
City, State and Zip Code _____
Attn: _____
E-mail Address: _____
Fax: _____
Additional Insured required? Yes No
Job Name, Description & #: _____
Location of Operations: _____
Job Start Date: _____ **Duration (months):** _____
Job Cost: \$ _____
Indicate if job involves:
 Condos Townhouses Apartments
 Multi-Unit Dwellings **If yes, How many units:** _____
Name Additional Insured(s): _____

GL Ad. Ins. Completed Operations: Yes No
Workers Compensation Waiver: Yes No
Auto Additional Insured/names: Yes No
Auto Waiver of Subrogation: Yes No

If there are any other special requirements or questions, please attach a copy of the requirements to this form and return by Email to yp@sjpinsuranceservices.com or sjpservice@gmail.com.

Name _____ **Date** _____

